Journal of Clinical Nursing 1999; 8: 527–534

Identifying approaches to meet assessed needs in health visiting

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Accepted for publication 5 November 1998

Summary

• An action research project, based in a single fundholding practice on the south coast of England, aimed to identify the health needs of families with resident children, then use the contracting system to redirect health visiting services to meet those needs.

• After assessing the health needs, it was necessary to assess the potential of a range of health visiting approaches that might be proposed to meet those needs.

• This paper explains how the approaches were assessed for use in the local area and why funding for two additional, innovative posts was deemed necessary.

• Despite the unsophisticated evidence base for health visiting interventions, a case can be made for commissioning particular service approaches by using a combination of survey data and results from controlled and uncontrolled service evaluations.

• The supportive focus of health visitor home visiting remains an appropriate use of existing resources, but the usual intensity of visiting may be insufficient for full effectiveness. To rationalize such services by targeting them only at individuals with established needs risks an exacerbation of deteriorating health trends across an area.

• Alternatively, augmenting home visiting with a community development approach to improve the adverse social environments in which families live may help to change the underlying factors that contribute to ill-health and prove more widely cost-effective.

Keywords: evidence-based practice, health visiting, prevention, service evaluations, social exclusion.

Introduction

Since implementation of the NHS & Community Care Act 1990 in the UK, there has been increasing emphasis

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on two principles introduced at that time. First, the internal market empowered purchasing authorities to set contracts with health care providers to meet assessed health needs in their local population. Second, decisions about approaches and services to be used should be rigorously assessed as to whether they are clinically effective or not. Proposed legislation changes the terminology and financial details of the internal market; instead of purchasers setting contracts, 'commissioners' will set 'service level agreements' (DoH, 1997). However, the principle of establishing services to meet assessed needs remains the same. Also, quality is to be assured through a system of clinical governance (NHSE, 1998), so evidence of clinical effectiveness will become even more important.

On the face of it, the principles seem straightforward and sensible, especially in a time of resource constraints. Given a certain number of individuals with known diagnoses (assessed needs), research information can be used to distinguish the relative merits of different treatment protocols and choices can be made accordingly. However, in health promotion and preventive care, the situation is more complex and the evidence base far less sophisticated. This paper is derived from an action research project based in a fundholding general practice on the south coast of England. The project aimed to identify health needs of families with resident children, then use the contracting system to redirect health visiting practice to meet those needs. Health visitors are expected to deliver proactive, preventive care across a population rather than simply reacting to established problems in individuals; the original idea was for existing services to be re-orientated according to the needs identified in the project. This paper describes a range of approaches that might have been implemented, explains how they were assessed for suitability in the local area and why a decision was finally reached to seek additional funds for two new posts.

Assessing health needs

A profile of health needs in the local area was drawn up, using formal epidemiological and demographic data; views of community practitioners, health commissioners and managers elicited by informal interviews and focus groups; and selected data from locally relevant research projects and studies. The main carers in 50 families with resident children were interviewed to discover their views about health, health needs and health services; a specific effort was made to elicit aspects of positive health as well as 'problems'. These views were analysed and integrated into the profile to identify which health needs to prioritize. The multiple sources of data were aggregated following Yin's (1994) case study approach as a mechanism for integrating data from incompatible datasets across geographical areas, GP caselists and different periods of time. In this way, it was possible to make use of qualitative data drawn from local community practitioners and ensure local relevance and utility within the practice list. The method and overall results have been reported elsewhere (Billings, 1996a, b; Cowley & Billings, 1997). Four key areas of health need and service provision were highlighted in the profile and thematic analysis of the interview data. These were:

- the health of children and young people, especially in relation to child protection;
- mental health at all ages, but especially among children and young people;
- the perceived value of home visiting and social support from professionals;
- the importance of social disruption and poverty in the local area.

These themes were used as an organizing focus in considering which approaches to health visiting it would be most appropriate to develop.

Identifying approaches

There were not sufficient resources within the action research project to carry out a full systematic review of all the potential approaches that might have been considered to meet such a wide-ranging set of health needs. Furthermore, the evidence base across these areas is quite variable, ranging from almost none to existing systematic reviews about specific issues. In the light of this dearth of material, Cowley (1996) has suggested that clarity is required first about the purpose of the preventive service to be provided: an emphasis on positive health promotion reflects the intended role of health visitors. Next, some theoretical links are required to indicate exactly how these interventions will target and influence the identified health needs. It is only when that theoretical base is sufficiently clear that it is possible to link proposed interventions to outcome and identify measures that will indicate whether or not there is a potential improvement in health as a result.

The ability to carry out randomized controlled trials, or reviews of such trials, is severely limited by the lack of these basic specifications to inform robust instrumentation. It is questionable, too, whether this 'gold standard' approach is ever likely to be suitable for evaluating such complex activities as those embedded within the currently universal health visiting service. Indeed, the experience of

undertaking a systematic review of health visitor domiciliary visiting prompted Robinson to ask, 'does the inability of the "gold standard" method to handle the evaluation of complex activities invalidate the evaluated activity itself?' (Robinson, 1998; p. 95).

However, a review of the literature was carried out so that potential approaches could be evaluated, not only on the strength of evidence of their effectiveness, but also according to how congruent they would be with the particular situation at the research site. This contributed to discussions about which approaches might best be implemented in the local area, given existing services and established skills among practitioners.

Child protection

There was twice the national incidence of detected child abuse in the local area. This trend was rising and especially significant in the fundholding practice where the research was sited, which had registered a particularly high proportion of local families where children were known to need protection. This is an important issue, given the long-term impact on individuals who have been abused. Family conflict and 'bad parenting' is associated with use of illicit drugs and crime among juveniles (Farrington, 1995; Rutter & Smith, 1995); lack of security and warmth in the family results in low self-esteem, risky behaviour and high levels of aggression (Maccoby, 1980); adult mental health suffers significantly as a result of childhood abuse (Glaser & Prior, 1997; Browne, 1988); and experience of being parented affects the child's future skills in parenting and ability to form relationships (Richman *et al*., 1982).

Unsurprisingly, therefore, health visiting services are increasingly focused on families where children are believed to need protection; indeed, in many areas family 'vulnerability' is recognized only in terms of potential child abuse (Appleton, 1997). One way of rationalizing limited services is to reduce their scope; however, the potential for creating stigma by targeting groups that are already disadvantaged is well acknowledged in the sociological literature. Furthermore, there is no valid and reliable way of predicting which families may abuse in future, although a great variety of invalid and unreliable checklists exist (Appleton, 1997). Most of these draw on features that abusive families are believed to have in common; they take no account of protective resources, have very poor sensitivity and show distressingly high false positive rates (Browne, 1995).

There is little research to demonstrate which approaches are likely to prevent abuse from happening, which is surprising given the important role that health visitors are supposed to hold in this field. One approach that might have been considered for introduction locally was the Child Development Programme introduced by Barker & Anderson (1988). It is not directed explicitly at reducing rates of child abuse, but this is an important by-product of a general support programme. It focuses on improving many areas of parent and child functioning, including nutrition, health, language, social and cognitive goals, early education and emotional development. The programme offers monthly support visits to first-time parents, ante-natally and during the first year of life. The visits are undertaken by specially trained health visitors using planned semistructured methods; parents learn through discussing informative cartoons that suggest strategies for tackling many of the child care issues which may arise. A detailed study, reviewing the sample of over 30 000 programme children in 24 health authorities, suggests that children whose parents are involved in the Child Development Programme can expect to have a 41% lower rate of registration on the Child Protection Register, and a 50% lower rate of physical abuse, compared with the adjusted levels in the same health authorities (Barker *et al*., 1992).

This programme might have been considered ideal for the particular situation, but the Programme Director maintains strict control over conditions of copyright, training of first parent visitors and the remaining health visitors in the area. Guarantees are sought and there is a charge to the employing authority for these services. The local provider unit had considered implementing this programme the year before the research project began, but negotiations had broken down and some antagonism remained.

Also, the local health visitors had since developed a form of working that involved setting up a specialist 'intensive service' for families facing difficulties in child care and management. The service was seen as under-resourced, having received a 30% increase in referrals for behaviour problems linked to dysfunctioning families and potential child abuse in the three years since it was established. However, the service had been audited closely, including recording 'before and after' views from users and practitioners, its performance was evaluated as 'very good'. There is a wealth of research to show that health visitors can learn and implement behavioural techniques and cognitive skills training (e.g. Angeli, 1994; Pritchard, 1994; Sutton, 1995; Davis *et al*., 1997) which are generally very effective in treating the childhood emotional and behavioural difficulties that occasionally deteriorate into abusive situations. In the light of the

success of this specialist team, it seemed unwarranted for the researchers to concentrate further on matters of child protection. However, it was clear that no reduction in this service could be suggested, and there was, perhaps, the potential to initiate some earlier preventive work, given its links with the other key areas identified as health needs.

Mental health

School nurses reported an increase in family breakdown detected at the 11-year-old assessment, with associated behavioural problems, self-mutilation and attempted suicide. Suicide rates for adults in the local area were well above national average; the families interviewed and local practitioners reported a lack of social support for increasing numbers of single parents and rising depression rates among pre- and post-natal mothers. The close links between mental health and the identified underlying difficulties in this area, which included poverty and disadvantage, child abuse, crime and escalating need, are well recognized in the literature (e.g. Brown & Harris, 1978; Broadhead *et al*., 1983; Holahan & Moos, 1985; Pound *et al*., 1985; Cockett & Tripp, 1994; Graham, 1994; Farrington, 1995).

Health visitors are well placed to promote mental health and there is increasing evidence of their effectiveness in this field. A recent systematic review of mental health promotion in high risk groups confirmed that it is possible to identify people who are vulnerable to mental health problems due to poor social environments or adverse life events (NHS CRD, 1997). This revealed the importance of high quality preschool education and support visits for new parents, which have been shown to improve mental health in children and parents in disadvantaged communities. It showed evidence that mental health problems in children of separating parents can be reduced by providing the kinds of behavioural and cognitive skills training implemented locally by the intensive family support team. It also highlighted the importance of emotional support, which will be considered further in relation to home visiting.

Randomized controlled trials have shown that use of the Edinburgh Postnatal Depression Scale (EPDS) can detect postnatal depression (Cox *et al*., 1987), that women respond well to non-directive counselling by their health visitor (Holden *et al*., 1989) and that preventative interventions can be effective (Elliot *et al*., 1985). A structured approach, combining use of the EPDS, non-directive counselling and preventative measures, has been shown to produce a shift towards positive mental health in the group as a whole as well as a significant reduction in the proportion of women whose scores indicate diagnosable depression (Gerrard *et al*., 1993).

These studies have shown that health visitors can be trained in the detection and management of postnatal depression, together with associated difficulties in the mother–infant relationship, and they can deliver an intervention that is both effective and highly acceptable to depressed mothers. Also, a follow-up study at 18 months showed that significantly fewer child behaviour problems were reported by mothers receiving brief interventions compared with those receiving routine care, indicating that the benefits of intervention may be sustained (Seeley *et al*., 1996). There is a clear potential benefit from growing up in a happy atmosphere, with associated childhood wellbeing and healthy mental development in the long term.

In this study site, health visitors were already making routine use of the EPDS to ensure early detection of postnatal depression and the general practice employed a counsellor to help with psychological problems once they had arisen. Once more, existing practice in the study area was shown to be directed appropriately, although the service was very over-stretched. There were two remaining areas of practice linked to mental health. These were the relevance of emotional support offered through home visiting and the impact of poverty and social disruption across the area.

Home visiting

Home visiting has been at the core of health visiting practice since the profession first developed in the middle of the nineteenth century. Local health visitors carried out the usual approach of targeting home visits on families identified from within a caseload that included all families with preschool children in their area of responsibility. Perhaps because the approach seemed so well established, it has not been widely evaluated in this country, although a systematic review of health visitor home visiting was underway at the time of this project (Robinson, 1998).

However, the results of experiments carried out in North America show that problems in pregnancy and infancy can be alleviated by intensive home visiting programmes undertaken by appropriately trained nurses, the nearest equivalent to the UK health visitor. Home visits during pregnancy led to teenage mothers having heavier babies, women who had previously smoked decreased their smoking and had fewer preterm deliveries, and the postnatal home visits were associated with a decrease in recorded child physical abuse and neglect during the first two years of life, especially by poor,

unmarried teenage mothers (Olds *et al*., 1986a, b). Children's detected injuries were reduced for up to two years after the programme ended (Olds *et al*., 1988) and, during the first four years after delivery of their first child, the 'visited mothers' who were unmarried and from low socioeconomic status households had fewer subsequent pregnancies and greater participation in the workforce than did their counterparts randomly assigned to comparison services (Olds *et al*., 1994).

Another randomized controlled trial was undertaken to determine the extent to which the findings from this study could be replicated with an African-American sample of primarily low income, unmarried women living in a major urban area (Kitzman *et al*., 1997). Again, the results were encouraging, showing a reduction in pregnancy-induced hypertension, childhood injuries and subsequent pregnancies among low-income women with no previous live births. The replicability of the original study in a very different part of the USA is encouraging, although there is still no direct evidence that such results would transfer to this country. Also, the number of home visits was far higher than the usual level undertaken in this country, being an average of seven home visits during pregnancy and 26 visits between birth and the child's second birthday. A detailed protocol was used to guide visitors in helping the women improve their health-related behaviours, care of their children and life-course development (pregnancy planning, educational achievement and participation in the workforce).

The frequency of visiting, and the structure used to guide visiting, are quite similar to the approach used in the Child Development Programme detailed above, which also emphasized the use of partnership and an empowering approach. Implementation of that programme brought about highly significant changes in almost every home environmental variable, as well as the children's developmental levels, when comparing intervention with control families (Barker & Anderson, 1988). A later evaluation was based on an action research rationale; it suggested that the most significant contribution to changes in the children occurred as a result of improvements in mothers' self-esteem (Barker, 1992).

It was clear that if any changes in practice were to be introduced in the local area, it should not be at the expense of the limited home visiting already carried out with the disadvantaged families. Given the unfortunate experience of earlier attempts to introduce the Child Development Programme into the town, it was also clear that it would be difficult to implement any other structured visiting schemes. Health visitors based at the practice promoted the idea of trying to increase their numbers so they could continue working in much the same way, but with greater consistency. The research cited earlier lends considerable support to this view, provided a systematic and empowering approach to visiting is implemented. Indeed, from a review of the literature, Farrington (1995) has suggested that an intensive health visiting programme, with small caseloads to allow such a system of structured visiting, might be successful in reducing hyperactivity, school failure and child conduct problems, and might ultimately reduce juvenile delinquency and crime. Such evidence appears to have influenced recent government thinking and moves to promote positive parenting and reduce social exclusion, through its proposed 'Surestart' and family support schemes (Home Office, 1998).

There were two other aspects to be considered in the local area. One was that interviewed parents of school-aged children expressed a wish to have a home visiting service similar to the health visiting service they remembered receiving. There is no research to support the effectiveness or otherwise of such a plan, but the profile provided clear evidence of the unmet needs of school-aged children. Also, worthy as it is to target individuals and families through home visits to help them overcome disadvantages in their personal situation, that approach does nothing to alleviate the underlying pressures facing them, or to change the wider psychosocial environment in which they live.

Poverty and social disruption

The central relevance of poverty highlighted in both the community profile and the interview data is reflected in an increasing amount of research looking at the impact of different status and income on health. There is growing interest in measures that may to be taken to improve variations in health status, as evidence accrues to demonstrate the potentially significant part that inequalities may themselves play in harming the overall health of populations (Wilkinson, 1996).

A number of contradictions and tensions arise between the different perspectives outlined in the literature. The causes of poor health are often framed in individual behaviours, risk factors and medical terminology; this literature underpins approaches such as the individually directed home visiting programmes listed above. There is a tendency for such interventions to address risk factors and pathology that are unequally distributed in the population, without taking into consideration why the inequality exists in the first place. Risk factors for disease are not the same as causes of inequalities (Niehoff & Schneider, 1993), so if they are used to determine

effectiveness in isolation, they may miss important aspects of the whole picture.

Furthermore, such illumination does not lead automatically to an understanding of how variations and inequalities arise, since they are mainly explained by drawing on social and population-wide theories (Lafaille & Fulder, 1993; Syme, 1996; Wilkinson, 1996). While this social focus has implications for the extent to which the NHS might legitimately be assumed to have a part to play in prevention, additional treatment costs attributable to these causes have been estimated at many millions of pounds (Lawson, 1997). There is growing pressure for NHS staff to become actively involved as part of a multiagency effort to tackle inequalities in health as well (Benzeval *et al*., 1995; DoH, 1998).

Community-based initiatives have long been associated with redressing inequalities in health and enabling disadvantaged groups to influence decisions affecting their health and lives (Farrant, 1991). Community development work has a long international history (Brokenshaw & Hodge, 1969; Dixon, 1989). The last two decades have witnessed an upsurge of interest and rapid growth of the community health movement in the UK, manifesting as a diverse and increasing number of groups, projects and initiatives applying a community-based approach to health (Somerville, 1984; Beattie, 1991). Community-based health interventions are associated with many different labels, foci, and degrees of interagency- and user-involvement (Somerville, 1984; Brown, 1997).

Concentrating only on contributory factors to disease tends to overlook the importance of salutogenic (that is, 'health-creating') resources that contribute to positive health, which is often a significant feature of community project work. Some projects have focused on equilibrating and evaluating service access and uptake between socio-economic groups, but this may not result in a decrease in inequalities (Gunning-Schepers & Gepkens, 1996). Instead, community-based initiatives entail increasing the expertise and capacity of people in difficult and disadvantaged situations to control their collective circumstances; these approaches are particularly suited to combating social exclusion. Many health visitors feel a natural affinity to this work; it is becoming increasingly prevalent within the profession, and there is growing interest in identifying rigorous methods of evaluating its effectiveness (e.g. Boyd *et al*., 1993; Suppiah, 1994; Craig, 1996; Gilbert, 1996; Billingham & Perkins, 1997; Brown, 1997).

Given the overwhelming extent of disadvantage in the area, it seemed unlikely that there would be any possibility of increasing the home visiting service enough to make a difference in preventive terms across the population served. However, using a community-based approach to capitalize on the untapped potential that people in the local area have themselves may reduce the anticipated cost of service provision. Targeting the underlying needs in a whole area, rather than the individuals who are affected, makes it possible to implement an approach that could potentially reduce mental and physical health problems by improving social cohesion, and thus the overall situation for this disadvantaged population.

Choice of approach

Taken overall, the literature review indicated that two of the key areas of need (child protection and the mental health of children and young people) were already well recognized within the local area. The evidence supported approaches already being used by health visitors in the area, although there were clearly insufficient staff to change the underlying causes that contributed to these overt, established needs. Given this evidence, it would have been quite inappropriate to have recommended reorienting the existing, very stretched home visiting services and intensive support service for families with identified needs. Indeed it would, potentially, be possible to improve outcomes for the most disadvantaged families if a massive increase and systematic approach to home visiting was implemented for families of preschool children, and health visitors at the study site would have welcomed such a recommendation.

However, even in the unlikely event of so large a resource being made available, this would have done little to change the underlying social disruption and exclusion affecting families with both preschool and school-aged children. This disruption was clearly evident by the poor physical and psychosocial environment in which young families were forced to live in many parts of the town. Evidence across the health needs profile and in the consumer views demonstrated the urgency attached to this, as well as highlighting the dearth of services to meet the preventive health needs of school-aged children and their families.

Finally, a decision was made to recommend enhancing service provision in two ways: by introducing a community development project in one of the most underserved areas of the town, and by developing a home visiting service for families of school-aged children to augment the existing over-stretched school nursing service. It was hoped that these two different services would complement one another, as one was targeting a fairly specific group with established needs, while the other would tackle underlying causes of ill health at a far more fundamental

level. The recommendations were each controversial in different ways. The complex and lengthy negotiations to establish funding and gain acceptance for the posts across the study area are reported elsewhere (Cowley & Billings, 1997). In due course, a full-time health visitor was appointed to develop each of these ideas; both positions appear to be flourishing and plans are underway to conduct formal evaluations of the new services.

Conclusions

There is renewed emphasis on ensuring that services are commissioned and clinically governed in a way that ensures that their effectiveness is clearly evidenced by research. This is rightly intended to avoid the waste of precious health service resources, and to outlaw any potentially dangerous practices. However, the health needs that are targeted by a wholly preventive service such as health visiting cannot readily be distinguished by the number of countable diagnoses or problems present in a population. Instead, a multiplicity of interlinked and underlying factors contribute across an area to create situations in which either poor health flourishes or positive health can be created. Despite their 'gold standard', randomized controlled trials cannot account for the many variables and long-term impact of interventions in such situations. As a result, it is often impossible to identify sufficient robust research to support the specific interventions that could be expected to make a difference.

However, as this paper demonstrates, it is possible to make a case for particular approaches to be commissioned to meet identified health needs, by using a combination of survey data and a mixture of controlled and uncontrolled evaluations. This is more likely to ensure that services are targeted efficiently and effectively at health needs than a commissioning approach that only considers interventions that have been subject to randomized controlled trials, ignoring any other form of evidence.

There is good evidence to suggest that the supportive focus of home visiting is an appropriate use of existing resources. In this area, the intensity of visiting was probably insufficient to be fully effective; this seems likely to be the case in many places where health visiting services have faced reductions. In some of those areas, attempts have been made to rationalize services by targeting them on individuals with established needs, according to strictly defined criteria. The evidence suggests that such an approach is unlikely to reverse, and may even exacerbate, deteriorating health trends across an area. Alternatively, using a community development approach to focus preventive actions onto the situation in which such individuals live may help to change underlying factors that contribute to ill-health, and prove more widely cost-effective. The experience of this study, however, suggests that this should be implemented in addition to existing services and not as an alternative to supportive home visiting.

Acknowledgements

The overall study was funded by South Thames Primary Care Development Fund. Additional financial support and help was provided by Roebuck House Surgery, Hastings and East Sussex Health Authority. Thanks to all concerned.

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